**DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED**

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1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

H. Reimbursement Methodology:

See Attachment 4.19 A&B, page 34-35

D. **Definition of Services.**

1. Healthy Start Program means a program designed to identify and address medical, nutritional, and psychosocial predictors of poor birth outcomes and poor child health by providing enhanced prenatal and postpartum services to pregnant and postpartum female recipients and enhanced follow-up services to identify high-risk infant and child recipients.

2. Case Management Home-Visiting Services means home-based, case management services which will assist high-risk infant or child participants in gaining access to needed financial, medical, social, housing, educational, mental health, counseling, and supportive services.

3. These services are targeted to specific high-risk groups of infant and child participants who are identified through the Healthy Start Risk Assessment Instrument for infants. The Infant Identification Form is completed by the community health nurse during the Healthy Start postpartum home visit. If the infant meets the Program's criteria for high-risk, the Case Management Home-Visiting Services are initiated at that time. Qualified infants and children, who are unknown to the community health nurse at the time of the postpartum visit, may be approved for Case Management Home-Visiting Services if the community health nurse completes the Infant Identification Form at the time of case-finding and the child meets the Healthy Start Program's criteria for high risk.

4. Healthy Start Risk Assessment Instrument means the form furnished by the Department to the provider for the purposes of documenting the results of the risk assessment and developing the participant's Plan of Care.

5. A unit of service is defined as one home visit by a Case Management Home-Visiting Services Coordinator. These services shall include the following:

   a. A face-to-face evaluation of a participant to determine the present condition, living environment, background, and needs. This may not include laboratory tests or a hands-on medical or psychological examination.

   b. Development of a home-visiting plan and its implementation, with the participation and approval of the participant's legally authorized representative or representatives. The representative is free to reject any or all parts of the plan and may request other services. The Case Management

Home-Visiting Services Coordinator may not enforce a plan of care or restrict the participant only to those recommended services.

c. Referral to providers selected by the participant's representative from among those qualified and available.

d. Assisting the participant in gaining access to the needed and desired services, and arranging for and linking the participant with those services.

e. Coordination of providers to whom the participant is referred, including managing and resolving conflicts between providers or between providers and the participant.

f. Providing the participant or representative with counseling concerning use of community resources and regarding health, social, educational, financial, housing, and other needs.

g. Advising the participant or representative on accessing government entitlement programs.

h. Coordinating with the participant's family members for implementation of the care plan, including counseling and training of family members as appropriate.

6. Case Management Home-Visiting Services may not be:

a. Provided as an integral and inseparable part of another covered Program service;

b. Provided as an administrative function necessary for the proper and efficient operation of the State's Medical Assistance plan;

c. Rendered in connection with the implementation of services under Sections 1915(b),(c), or (g) of the Social Security Act;

d. Part of institutional discharge planning; or

e. Provided by the EPSDT/Healthy Kids Program Manager during the percentage of time covered by grant funds from the Healthy Kids Program.

E. **Qualifications of Providers.**

1. General requirements for participation in the Medical Assistance Program are that providers shall:

a. Meet the following licensure requirements, and verify the licenses and credentials of all professionals employed by the provider:

1) Registered nurses providing Case Management Home-Visiting Services for the Healthy Start Program shall be licensed in the jurisdiction in which services are provided.

2) Social workers providing Case Management Home-Visiting Services for the Healthy Start Program shall be licensed in the jurisdiction in which services are provided, and

3) Licensed practical nurses providing Case Management Home-Visiting Services for the Healthy Start Program shall be licensed in the jurisdiction in which services are provided;

b. Apply for participation in the Maryland Medical Assistance Program using an application form designated by the Department of Health and Mental Hygiene;

c. Be approved for participation by the Maryland Department of Health and Mental Hygiene;

d. Have a provider agreement with the Department of Health and Mental Hygiene in effect;

e. Be identified as a Maryland Medical Assistance Program provider by issuance of an individual provider number;

f. Verify the eligibility of recipients;

g. Accept payment by the Medical Assistance Program as payment in full for services rendered and make no additional charge to any person for the covered services specified in Section D. "Definition of Services" above;

h. Provide services without discrimination on the basis of race, color, sex, national origin, marital status, physical or mental handicap;

i. Maintain adequate records concerning service provision for a minimum of 5 years and make them available, upon request, to the Maryland Department of Health and Mental Hygiene or its designee.

j. Not knowingly employ or contract with any person, partnership, or corporation which has been disqualified from the Maryland Medical Assistance Program to provide or supply service to Medical Assistance recipients, unless prior written approval has been received from the Department of Health and Mental Hygiene;

k. Agree that claims rejected for payment due to late billing may not be billed to the participant;

l. Not place a restriction on the recipient's right to choose the provider;

m. Agree that if the Medical Assistance Program denies payment or requests repayment on the basis that an otherwise covered service was not medically necessary or has not been preauthorized, the provider may not seek payment for that service from the participant; and

n. Be selected by the participant from among qualified providers.

2. Specific requirements for participation in the provision of Case Management Home-Visiting Services are that providers shall:

a. Be a Home-Visiting Services provider employing appropriately qualified registered nurses who have demonstrable experience in serving high-risk and low-income maternal, infant, and child populations;

b. Provide directly or subcontract for the provision of three or more Specialty Services;

c. Receive funding through, or be a subcontractor of an agency which receives funding through, the Maternal and Child Health Services Block Grant;

d. Demonstrate expertise in serving high risk and low-income maternal, infant, and child populations, including pregnant adolescents;

e. Contact the participant within 10 working days of the receipt of the referral, unless client-related extenuating circumstances are documented;

f. Have formal policies and procedures which specifically address the provision of Home-Visiting services to maternal, infant, and child populations;

g. Make records available to the Program of Home-Visiting services provided to participants;

h. Be knowledgeable of the eligibility requirements and application procedures of the applicable federal, State, and local government assistance programs;

i. Maintain a current listing of medical, social, housing assistance, mental health, financial assistance, education and training, counseling, and other support services available to low income pregnant women and children;

j. Strictly safeguard the confidentiality of the participant's record so as not to endanger the participant's employment, family relationships, and status in the community;

k. Agree to on-site visits by Department staff to monitor adherence to the covered services for Enriched Home-Visiting Services; and

l. Have an agreement with the Department for provision of Enriched Home-Visiting Services and Case Management Home-Visiting Services under the Healthy Start Program.

3. A Case Management Home-Visiting Services Coordinator is an individual, employed by the Home-Visiting Services Provider, who is one of the following:

a. A registered nurse;

b. A licensed social worker;

c. A licensed practical nurse; or

d. An individual with a bachelor's degree from an accredited college or university, who works under the direct supervision of a registered nurse or licensed social worker, and who has at least two years of experience rendering clinical casework.